DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11031 (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PSYCHOTHERAPY ATTACHMENT (PA/PSYA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.
Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Psychotherapy Attachment (PA/PSYA) Completion Instructions (HCF 11031A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)	2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name — Performing Provider	5. Performing Provider's Medicaid Provider Number (optional)
6. Telephone Number — Performing Provider	7. Discipline — Performing Provider
8. Name — Prescribing Provider	9. Prescribing Provider's Medicaid Provider Number

SECTION III — DOCUMENTATION

10. Diagnosis

Axis I a) _____

b) _____

Axis II _____

Axis III _____

Axis IV (optional) ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 0

Axis V (past year) (optional) _____

11. Date Treatment Began	12. Diagnosed by:
	❑ Clinical Exam ❑ Psychological Testing ❑ Other (specify) _____
13. Consultation	14. Results of Consultation
❑ Yes ❑ No	

Continued

SECTION III — DOCUMENTATION (Continued)

15. Presenting Symptoms

Severity: ❑ Mild ❑ Moderate ❑ Severe

16. Is the recipient's intellectual functioning significantly below average?
❑ Yes ❑ No

17. If "yes" to Element 16, what is the recipient's I.Q. score or intellectual functioning level?

18. Historical Data

Give relevant social and school history including development (if under 18), treatment history, past mental status, diagnosis(es), etc. (Attach additional sheets if necessary.)

19. Present GAF (DSM)

Is the recipient progressing in treatment? ❑ Yes ❑ No

If no, explain.

Continued

SECTION III — DOCUMENTATION (Continued)

20. Present Mental Status / Symptomatology (include progress since treatment was initiated, or since last authorization)

21. Updated / Historical Data (family dynamics, living situation, etc.)

22. Treatment Modalities

❑ Psychodynamic ❑ Behavior Modification ❑ Biofeedback ❑ Play Therapy

❑ Other (specify) _____

23. Number of Minutes Per Session

Individual _____ Group _____ Family _____

24. Frequency of Requested Sessions

❑ Monthly ❑ Twice / month ❑ Once / week

❑ Other (specify) _____

25. Total Number of Sessions Requested

26. Psychoactive Medication? ❑ Yes ❑ No

Has there been a medication check in the past three months? ❑ Yes ❑ No

If yes, names and dosage(s) _____

27. Rationale for Further Treatment

Continued

SECTION III — DOCUMENTATION (Continued)

28. Goals / Objectives of Treatment

29. What steps have been taken to prepare recipient for termination of treatment?

30. Does the provider see other family members in a separate process? If yes, give rationale for seeing multiple family members.

31. **SIGNATURE** — Performing Provider	32. Date Signed
33. **SIGNATURE** — Recipient (optional)	34. Date Signed
35. **SIGNATURE** — Supervising Provider	36. Date Signed

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